HEADQUARTERS
UNITED STATES EUROPEAN COMMAND
UNIT 30400
APO AE 09131-0400

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# HEALTH SERVICE SUPPORT

Medical Crisis Response

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1. **Summary**. Publication establishes policies for coordinating the response of the United States European Command (USEUCOM) health service support system to short notice crisis situations involving US forces and US citizens. Crisis response teams in this publication are organized and equipped to mitigate the medical effects of an event.

2. **Applicability**. USEUCOM Directive (ED) 67-5 establishes policy, assigns responsibilities, and prescribes procedures for a USEUCOM medical crisis response for Headquarters, USEUCOM, and its component commands.

3. **Internal Control Systems**. This directive does not contain internal control provisions and is not subject to the requirements of the internal management control program. For HQ USEUCOM and subordinate joint activities, the applicable internal control directive is ED 50-8, Internal Management Control Program.

4. **Suggested Improvements**. The proponent for this publication is the HQ USEUCOM, ECJ4-Medical Readiness Division. Recommended changes should be forwarded to HQ USEUCOM, ATTN: ECJ4-MR, Unit 30400, APO AE, 09131 or PLAD: HQ USEUCOM VAIHINGEN GE// J4MR//.

5. **References**. See Appendix A.

6. **Explanation of Terms**.

a. For purposes of this directive, the term ”MASCAL situation” is defined as: "a mass casualty situation in which an excessive disparity exists between the patient load and the health service support (HSS) capabilities available for its conventional management."

b. Nonstandard units. This term when used in context of this ED will refer to those task-organized, medical crisis response units lacking a standard service component requirements document (i.e., Army and Marine Tables of Organization and Equipment, Air Force Allowance Standards, Navy Manning Documents).

c. Pallets are defined as standard USAF 463L cargo pallets.

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This Directive supersedes ED 67-5, dated 22 May 2002.

d. Marshaling time is defined as the time when a unit should be at the Aerial Port of Embarkation (APOE) with all personnel and equipment required to accomplish the mission in a ready-to-load status. It is measured from the time a unit is alerted to the time that unit is ready to deploy. This readiness standard is described in paragraph 7 of this ED.

e. Medical Crisis Response Teams (MEDCRTs) refers to the medical teams organized and directed to respond to a short notice crisis situation. Specifically, two MEDCRTs are directed: a Surgical Response Team (SRT) and a Mental Health Response Team (MHRT).

7. **Responsibilities**.

a. Commander, U.S. European Command (CDR USEUCOM).

(1) Direct and coordinate a Health Service Support (HSS) response to crisis situations. This includes associated logistics, force protection, command, control, and communications.

(2) Establish medical personnel readiness requirements for component commands.

(3) Coordinate MEDCRT blood support through the EUCOM Joint Blood Program Office (JBPO).

(4) Monitor theater medical forces to minimize impacts on peacetime health care systems during a crisis response.

(5) Maintain and annually publish the component on-call rotation schedule for the rotating MEDCRT teams.

b. Commanding General, United States Army Europe (CG, USAREUR); Commander, United States Naval Forces, Europe (CDR USNAVEUR); Commander, United States Air Forces in Europe (CDR USAFE).

(1) Plan, program, equip, train, and maintain mission capable MEDCRTs for rapid HSS response to a crisis situation as described in this directive.

(2) Provide hospitalization for patients evacuated from the crisis location.

(3) Monitor and coordinate HSS readiness status of all MEDCRTs within component command. Notify EUCOM of shortfalls or limiting factors affecting component MEDCRT mission capabilities via message 30 days prior to assuming MEDCRT duty responsibilities. Message should include status, problem, action taken to resolve, get well date, and whether or not the component needs relief from task.

(4) Arrange for transportation of MEDCRTs, and their associated equipment and supplies, to the embarkation site for deployment and onward movement to the crisis location or forward area.

(5) Coordinate all classes of resupply for deployed MEDCRTs.

(6) Support EUCOM in monitoring movement and condition of patients and MEDCRTs.

(7) Exercise MEDCRTs in events that integrate, validate and refine MEDCRT readiness, capabilities, and procedures (e.g., MEDFLAGs, MEDCEURs, etc.).

(8) Ensure MEDCRT members have valid official passports. Maintain a current list of all MEDCRT member names, ranks, official passport numbers, expiration dates, and issue location at the component headquarters to expedite visa requirements.

(9) Coordinate required utilities, berthing, messing, transportation, command, control, communications, laundry, and force protection support as required.

(10) Provide training guidance and opportunities to insure critical MEDCRT members are cognizant of the respective CRT expectations and capable of meeting mission requirements.

(11) Provide reporting guidance to include situational reporting (SITREP), medical surveillance reporting IAW ED 67-9, and other reports as deemed appropriate by components or higher headquarters.

(12) On order, provide the following MEDCRTs with the indicated capabilities:

(a) Surgical Response Team (SRT) provides rapid response resuscitative surgery and emergency medical support. The SRT also facilitates onward movement to higher levels of care.

1. Deploy unit and personal equipment on one C-130 (limited to two 463L pallets and 10 personnel). **Note: If operational constraints dictate, a smaller surgical capability is embedded in the 10-person team. Line leadership will be apprised of the risk and lack of patient holding capability if a smaller surgical team is directed. Ensure a robust aeromedical evacuation plan is in place to mitigate the reduction in capability.**

2. Provide life saving surgical intervention to stabilize 10 patients and capability to hold 2 patients for a 24-hour period.

3. Be capable of providing individual shelter, power, and light for the team for 48 hours.

4. Marshal the SRT at the designated embarkation point within 18 hours of notification.

5. Initial blood supply should be coordinated with the closest medical treatment facility (MTF) and joint blood program officer (JBPO). The blood inventory consists of type O packed red blood cells (PRBC). The MTF and SRT should coordinate with the JBPO to backfill the MTF and to fill out the SRT's projected requirements in accordance with reference k. Once

deployed and operational, all resupply requests must be coordinated through the JBPO. Because the SRT is responding to a crisis scenario, level II transfusion practices will be observed. For specific blood guidance, refer to appendix B. Deploying SRTs must ensure that an appropriate blood bank-type refrigerator (i.e., Thermopol or Maxicool) is part of the deployment equipment package (refer to appendix B for specific blood guidance for SRTs).

(b) Mental Health Response Team (MHRT). Provides rapid deployable mental health personnel and equipment to perform in-theater prevention and outreach services including command consultation, critical incident stress management, education and operation of a crisis stress facility if required.

1. Provide sufficient mental health professionals and support staff to render immediate mental health intervention during, or after a military operation or crisis situation.

2. A board certified mental health professional in the grade of O-3 or greater will lead the MHRT.

3. Be prepared to marshal the MHRT at the designated embarkation site within 48 hours of notification.

(c) Service components will share SRT and MHRT crisis response alert duties on a rotating, monthly basis as scheduled by HQ EUCOM. When the annual schedule is published, each component will acknowledge their duty months via message to HQ EUCOM. If a component MEDCRT is alerted for deployment by USEUCOM, the next component on the schedule will assume the remainder of that month's duty as well as its own scheduled month. Once deployed, the MEDCRT will remain in place for the duration of the mission or until properly relieved by HQ USEUCOM or the supported COCOM.

c. CG, USAREUR.

(1) Provide a Radiological Advisory Monitoring Team (RAMT) that is capable of deployment within 24 hours of notification.

(2) Be prepared to provide Landstuhl Regional Medical Center as the primary casualty receiving center as necessary.

(3) Provide Center for Health Promotion and Preventive Medicine-Europe (CHPPM-E) consultation services as needed.

(4) Provide consultation or expertise on rotary-wing medical evacuation capabilities as required.

d. CDR USNAVEUR.

(1) Provide Navy Environmental and Preventive Medicine Unit Seven (NEPMU-7) consultation services as needed.

(2) If assets are available, provide fixed-wing aircraft and aircraft crews to augment USAFE and AMC assets in the movement of MEDCRT personnel, material and patients, as required.

(3) If Amphibious Readiness Group (ARG) is available, augment crisis response forces with rotary-wing aircraft and crews for patient evacuation, transport of MEDCRT personnel, and the movement of materiel as required. Function as primary casualty receiving and treatment ship.

e. CDR USAFE.

(1) Coordinate fixed-wing aeromedical evacuation (AE) support for patients generated by the crisis. Provide aeromedical evacuation assets as needed, including Critical Care Air Transport Teams or an equivalent capability to support movement of patients needing critical care.

(2) Provide aircraft and crews for movement of MEDCRT personnel and supplies responding to the crisis.

(3) Regulate patients, through the Theater Patient Movement Requirements Center-Europe (TPMRC-E), to most appropriate MTFs.

f. Commander, Special Operations Command, Europe (CDR SOCEUR). Provide unique capabilities in support of medical crisis response as required.

8. **Policy**.

a. Combatant command (COCOM) of theater HSS resources is maintained by CDR USEUCOM. In a crisis situation within the EUCOM AOR, operational control (OPCON), tactical control (TACON), direct liaison authority (DIRLAUTH) of HSS resources may be delegated to a JTF or TF commander. The USEUCOM Command Surgeon and/or appropriate lead component surgeon will provide technical guidance and direction to the senior medical officer on the scene. EUCOM HSS resources deployed to locations outside EUCOM's AOR will be employed in accordance with established "supported" and "supporting" command relationships defined in JCS Pubs and applicable operations orders.

b. HSS is a national responsibility. The HSS structure will be based on the principle of joint cooperation and effective coordination of all available HSS resources. Allied patients, host nation patients, and personnel from non-governmental organizations (NGO) or private voluntary organizations (PVOs) in the crisis area will be provided care by U.S. forces personnel on an emergency basis in accordance with appendix C, unless other agreements are in place. Coordination for the repatriation of these patients will be initiated with the appropriate authority as soon as their medical condition permits.

c. All HSS assets within EUCOM are available to support crisis situations within EUCOM's AOR as a part of a continuing medical response. Further, EUCOM HSS assets will support, upon request and within capability, crisis situations within other unified command AORs, in accordance with existing agreements or as directed by higher authorities.

d. Emergency hospitalization will be provided in the nearest available host nation, allied, or US medical treatment facility (MTF) with HSS capability commensurate with the patients' requirements. US patients will be repatriated to US facilities as soon as possible. Medical regulating of patients from the crisis location to a MTF for follow-on or definitive care will be coordinated between the senior medical officer and the Theater Patient Movement Requirements Center-Europe (TPMRC-E). The preferred mode of evacuating patients is by rotary-wing medevac or fixed-wing aeromedical evacuation. (See ED 67-2 for more complete details.)

e. Blood and blood product support will be provided for EUCOM HSS crisis response efforts. Crisis or contingency requirements for blood or blood products resupply that are beyond the Service component commands' blood program capability will be coordinated through the EUCOM JBPO per reference K. Only blood procured through Food and Drug Administration (FDA) approved sources is to be used on US personnel. Upon coordination with host nation medical sources, locally sourced blood products may be used on indigenous personnel. Ensure that US sourced blood products are stored separately from other sourced products.

f. Every effort will be made to redistribute medical resources for validated medical requirements within the EUCOM AOR, through optimal intra-service and inter-service coordination. CONUS based HSS may be required to support a crisis or contingency situation if the magnitude of medical requirements exceeds the theater capability. All requests for CONUS based HSS will be coordinated with the HQ USEUCOM/J4 Medical Readiness Division.

g. EUCOM component commands will maintain HSS assets prescribed by this directive in a high state of readiness for rapid deployment.

9. **Procedures**.

a. When CDR USEUCOM validates a requirement for a medical response to a crisis, EUCOM MEDCRTs will be placed on deployment alert or directed to deploy by the European Plans and Operations Center (EPOC) via the component commander.

b. HSS response to a MASCAL situation may be provided by one or more component MEDCRTs, or by specially configured MEDCRTs jointly staffed by component medical services.

c. Selected US MTFs will be alerted, as necessary, to receive evacuated patients. Joint regulating of patients will be governed by the immediacy of the patient's needs and HSS availability in accordance with reference D of appendix A.

10. **Command and Control**. CDR USEUCOM will exercise COCOM and directive logistics authority in accordance with reference C of appendix A.

a. If a JTF has been established to manage the crisis situation, then command and control will be exercised through the JTF.

b. When a JTF does not exist, then command and control will be exercised from USEUCOM through component command channels.

FOR THE COMMANDER:

OFFICIAL:

JOHN B. SYLVESTER
Lieutenant General, USA
Chief of Staff

DANIEL A. FINLEY
MAJ, USA
Adjutant General

APPENDICES
A- References
B- Blood Guidelines for SRTs
C- Medical Rules of Engagement for Determination of Patient Care Eligibility

DISTRIBUTION:
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## APPENDIX A

REFERENCES

a. Joint Pub 0-2, Unified Action Armed Forces (UNAAF), 10 July 2001.

b. Joint Pub 4-02, Doctrine for Health Service Support in Joint Operations, 30 July 2001.

c. Joint Pub 4-02.1, Joint Tactics Techniques and Procedures for Health Service Logistic Support in Joint Operations, 6 October 1997.

d. Joint Pub 4-02.2, Joint Tactics Techniques and Procedures for Patient Movements in Joint Operations, 30 December 1996.

e. CJCSM 3122.01, Joint Operations Planning and Execution System (JOPES), Planning, Policies, and Procedures, Volume II, 14 July 2001.

f. CJCSM 3150.02, Global Status of Resources and Training System (GSORTS),15 April 2000.

g. Joint Staff Memorandum, MCM-0006-02, 01 February 2002, Deployment Health Surveillance and Readiness.

h. Department of Defense Directive 6000.12, Health Services Operations and Readiness, with Change 1, 20 January 1998.

i. Department of Defense Instruction 6000.11, Medical Regulating, 9 September 1998.

j. ED 67-2, USEUCOM Patient Movement System, XX January 2004.

k. ED 67-4, USEUCOM Joint Blood Program, 22 August 1999.

l. ED 67- 9, USEUCOM Deployment Health Surveillance and Readiness, 01 June 2000.

m. STANAG 2879-3, Principles of Medical Policy in the Management of a Mass Casualty Situation, 7 September 1998.

## APPENDIX B

BLOOD GUIDELINES FOR SRTs

1. **SUMMARY**. MEDCRTs possess extremely limited laboratory capabilities. Specifically, a MEDCRT does not possess any capability to perform blood bank testing, to include ABO grouping. Therefore, blood inventory is limited to only Type O packed red blood cell (PRBC) units. If the physician determines that a blood transfusion is needed to save the life of a patient and the patient cannot be immediately evacuated to a higher echelon medical facility, then transfusions must be given based on the following procedures.

2. **Transfusion Procedures:**

a. Women of child-bearing years have priority for Rh negative blood.

b. If there is not enough Rh negative blood to meet all of the needs, the use of Rh positive blood becomes an emergency requirement to save the life of the patient.

3. **Medical Implications**:

a. FEMALES: Transfusing Rh positive red blood cells to Rh negative females may result in future complications if the female is of child-bearing age. If this female develops an anti-D antibody and a future fetus is Rh positive, hemolytic disease of the newborn may result. Thus, it is paramount to reduce the transfusion of Rh positive blood to Rh negative females of childbearing age.

b. MALES: The impact of sensitization on males and the health care system is not quite as great as females. If a male develops an anti-D antibody, the only future problem area comes if the patient needs a blood transfusion in the future. At that point, the transfusing facility must ensure that only Rh negative blood is used. If not, a delayed transfusion reaction can be expected.

4. **Reporting and Record-keeping**:

a. The deployed MEDCRT must stay in contact with the JBPO either through telephone, email or blood reports (BLDREP).

b. The deployed MEDCRT will utilize blood inventory tracking reports to maintain accountability and disposition of all blood products received. The two main reports are the Disposition Report and, in the event of blood transfusions, Transfusion Report. Reference *Joint Blood Program Handbook*, Army TM 8-227-12, Navy NAVMED P-6530, Air Force AFH 44-152 and *EUCOM Directive 67-4, dated 22 August 02.*

c. All blood records will be maintained, in an orderly system, to include all shipping documents, disposition reports and transfusion reports. Upon redeployment, all blood records will be boxed and shipped via certified mail to HQ USEUCOM Joint Blood Program Office, Building 3738, Room 104, CMR 402, APO AE 09180.

5. **Storage Guidelines**:

a. PRBC units must be stored at 1 to 6 $^{o}$ C.

b. It is preferable to keep blood units in a blood bank-type refrigerator that has an alarm and a continuous temperature monitoring system (i.e. Thermopol NSN: 4110-01-287-7111). If the refrigerator does not have a continuous temperature monitoring system, then one of the team members must check and record the temperature every four (4) hours.

c. If a refrigerator is unavailable or malfunctions, then the blood units may be kept in the blood-shipping box. The box must be repacked every 48 hours using 14 pounds of wet cubic ice. **NEVER USE BLUE ICE OR CHEMICAL ICE PACKS**. As ambient temperatures rise, re-icing will be required more frequently. A technician must check and record the temperature every four (4) hours.

# APPENDIX C

Medical Rules of Engagement for Determination of Patient Care Eligibility

The following pages of this appendix provide guidance to USEUCOM medical units to assist in the determination for providing medical treatment and potential medical evacuation.

| | CATEGORY OF PATIENT | DOCUMENTS REQUIRED | EMERGENCY | STANDARD EVACUATION | NON-EMERGENCY | ADDITIONAL INFORMATION |
|---|---|---|---|---|---|---|
| **1** | US Active Members; Active Duty (AD) & Active Guard Reserve (AGR) | Valid ID Card | Yes | Yes | Yes (Aid Station) | Assess to determine treatment in the MTF versus sending back to aid station; educate regarding sick call procedures in area of operations; evacuate to central region as warranted by medical condition. |
| **2** | US Reserve Service Members; Army National Guard & Reserve Component serving in a Title 10 status | Valid ID Card & TDY Orders | Yes | Yes | Yes (Aid Station) | Same as 1 above. Note: For routine care, treat only injuries/illnesses incurred/aggravated while on or enroute to training |
| **3** | Retired (US) Service Members (regardless of present employer) | Valid ID Card and/or Invitational Orders | Yes | Space Available | Space Available | Non-emergent care may be subject to availability of services; transfer to Host Nation (HN) facility or evacuate to central region as warranted by medical condition. |
| **4** | Federal Civilian Employees (e.g., US citizens working for DOD in support of the current mission | Valid ID Card & Orders | Yes | Yes | Yes | Care authorized at no cost to employee; non-emergent care may be subject to availability of services. |
| **5** | NATO Forces Non-US, Non-NATO Forces in support of the current operation | Valid ID Card and/or Invitational Orders | Yes | No | No (Unless authorized with a Multinational Integrated Medical Unit or Implementing Arrangement) | Stabilize, then refer to their national medical system as soon as emergency period ends. Note: Evacuation to central region requires diplomatic clearance; evacuation to CONUS requires approval by the Service Secretary of the component providing the support. |

| | | | EXTENT OF CARE | | | |
|---|---|---|---|---|---|---|
| | **CATEGORY OF PATIENT** | **DOCUMENTS REQUIRED** | **EMERGENCY** | **STANDARD EVACUATION** | **NON-EMERGENCY** | **ADDITIONAL INFORMATION** |
| **6** | Civilians in Emergency/Foreign Or National Disaster: | The following categories of patients should only be provided emergent care, and must be transferred as soon as patientsbecome stable. Patients who are ineligible, but present to the MTF seeking emergency care shall be evaluated and treated only if the physician determines that a patient care emergency exists. Reference Note 1 for specifics regarding triaging prior to transporting civilian casualties to the echelon three facility. Treatment of civilians is required when injuries (regardless of severity) are caused by or a direct result of US or allied forces' actions: transfer to appropriate civilian authority as soon as possible. On request of a life, limb or eyesight saving movement, the senior medical officer or JTF-Surgeon may approve movement of ineligible US citizens when adequate care us locally unavailable, and suitable commercial evacuation support is neither available, feasible, nor adequate. | | | | |
| **6a** | Local Nationals | ID Card (if available) | Yes | No | No | Emergency care is authorized; transfer to local hospital as soon as emergency period ends. |
| **6b** | Non-Government Organizations/ Private Volunteers | | | | | In the AOR pursuant to Invitational Orders in support of DOD |
| **6c** | (1) Red Cross supporting US Forces | Picture ID | Yes | Yes | Yes | Non-emergent care will be subject to availability of services. |
| **6d** | (2) Peace Corps/ Beneficiaries of the Public Health Service | Picture ID & Authorization letter from Peace Corps Officer | Yes | Yes* | No* | * When coordinated with local representative. ** If space is available, non-emergent care may be provided; care must be authorized by letter. |
| **6e** | (3) Civilian religious leaders/ groups; celebrities/ entertainers; athletic consultants or instructors; representatives of social agencies/ educational institutes | Picture ID & Invitational Travel Order | Yes | No* | No | Emergency outpatient care authorized without charge; charges are incurred for inpatient care. * Routine evacuation support is not authorized; see exception at item #6 above. |

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|---|---|---|---|---|---|---|
| | | | **EXTENT OF CARE** | | | |
| | (4) USO Professionals | USO ID & USO Form 2FI-19029-F | Yes | No* | No | Stabilize, then refer to their health care system as soon as emergency period ends. * Routine evacuation support is not authorized; see exception at item #6 above. |
| | (5) Contractors | ID Card & US Passport | Yes | No* | No | Refer to contractor medic; charges are incurred for treatment; notify the MTF CDR for decisions on non-US passport holders. * Routine evacuation support is not authorized; see exception at item #6 above. |
| | (6) Press & Local National Interpreters | Picture ID & Invitational Travel Order | Yes | No* | No | Emergency outpatient care authorized without charge; charges are incurred for inpatient care. * Routine evacuation support is not authorized; see exception at item #6 above. |
| 7 | Department of State Designees | Valid ID Card | Yes | Authorized forward MEDEVAC (ground/air) to appropriate medical facility | Yes | Based on the existing MOU, provide the level of medical care that is required same as that provided to US Armed Forces. Referrals/transports from area of operations to home nation is a national responsibility. |
| 8 | Detainees | Picture ID Card (if available) | Yes | No* | Yes | Provide the level of medical care that is required for US Armed Forces. Transfer to detainee collection point as soon as treatment period ends. * Routine evacuation support is not authorized; see exception at item #6 above. |

Note: Guidance on Triage Prior to Transporting Civilian Casualties to the Medical Treatment Facility (MTF).
Triage of ill/injured civilians must occur prior to transport of civilian casualties to avoid evacuating non-critical casualties to the MTF.
Treatment options include:

a. Emergency care and evacuation to the MTF for life, limb, eyesight threatening injuries.
b. Emergency care to prevent deterioration and evacuation to civilian treatment facility for non-life threatening injuries.
c. First aid for minimal injuries.